Commonwealth Of Kentucky

Health Insurance Application

PY 2005

(*for Use By the **Judicial and Legislators Retirement Plans***)

MUST BE COMPLETED BY THE INSURANCE COORDINATOR

MAIL APPLICATION TO:

KY Judicial Form Retirement System
305 Ann Street, Rm 302
State National Bank Bldg
Frankfort, KY 40601

Insurance Effective Date ☐☐ / ☐☐ / ☐☐☐☐

Home County ☐☐☐ **Contiguous County** ☐☐☐

Co. Last Employer ☐☐☐ **Company Number** ☐☐☐☐☐

Reason for Application ☐ < New Retiree ☐ < Open Enrollment ☐ < COBRA ☐ < Other**
☐ < Move Out of Service Area* ☐ < Previously Waived**

* If Moving Out of the Service Area, enter the Qualifying Event Date: _____

** If you Previously Waived or marked "Other", enter the Qualifying Event Date AND a description of the Qualifying Event: _____ (Date) _____ (Description)

SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying for this coverage? ☐ Yes ☐ No If "NO", what is your relationship to the retiree? ☐☐

RETIREE (Required) SSN ☐☐☐-☐☐-☐☐☐☐ _____ Retiree Name (First, MI, Last)

APPLICANT (If retiree is not applying) SSN ☐☐☐-☐☐-☐☐☐☐ _____ Applicant Name (First, MI, Last)

APPLICANT Specific Information Check here ☐ if address change/correction is requested.

_____ Street Address

_____ PO Box / Apt. #

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

_____ City, State, Zip Code

_____ County of Residence

_____ Country/Mail Code -- If NOT U.S.A.

( ) - _____ Primary Phone Number

Smoking Status Were you a smoker on 7/1/04? Yes ☐ No ☐

Gender ☐ < Male ☐ < Female

Marital Status ☐ < Married ☐ < Single

SECTION II: PLAN SELECTION

1. County of Coverage (Check only one)	2. Plan Code	3. Option	4. Level of Coverage	5. Cross-Reference
☐ < Home ☐ < Contiguous	☐☐☐ *If waiving, enter 999 and go to Section VII. If selecting coverage, see page 13 of the Health Insurance Supplement.*	☐ < Commonwealth Essential ☐ < Commonwealth Enhanced ☐ < Commonwealth Premier	☐ < Single ☐ < Parent Plus ☐ < Couple ☐ < Family	Not Applicable
Name of County of Coverage	Reason for waiving, if applicable			

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

If you elected Single in Section II, box 4, go to Section VII on page 2.

Social Security Number	Name (First, MI, Last)	Gender Circle One	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

SECTION IV: Not Applicable

SECTION V: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if you or your spouse have a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation.

Dependent's Social Security Number

☐☐☐-☐☐-☐☐☐☐

☐☐☐-☐☐-☐☐☐☐

_____ Custodial Parent Name

All Dependents? ☐ < Yes

_____ Custodial Parent Address

_____ Country / Mail Code (If not USA)

Applicant's SSN(from Page 1, Section I)

SECTION VI: NOT APPLICABLE

SECTION VII: AUTHORIZATION AND CERTIFICATION

* My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge.
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
* I understand that any material misrepresentation or material omission contained herein may be used to reduce or deny a claim or void the contract.
* I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in the retiree health insurance plan.
* I agree that the selected benefits may only be changed during Open Enrollment or in connection with a Qualifying Event.
* I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the health insurance benefits I have selected.
* My signature below certifies that I have read the Health Insurance Handbook and agree to be bound by its terms and conditions. All information listed on this application was completed with knowledge of the Handbook's terms and conditions, and I accept full responsibility for any deficiency concerning my application due to a failure to conform to the Handbook's terms and conditions.

Retiree Signature or Applicant Signature (if other than Retiree) _____ Date _____

Retirement/Insurance Coordinator Signature _____ Date _____

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JUDICIAL AND LEGISLATORS RETIREMENT PLANS

Reason for Application

- **New Retiree:** Check this box if you are a new retiree of the Judicial or Legislators Retirement Plans.
- **Open Enrollment:** Check this box if you are filling out this application due to Open Enrollment.
- **COBRA:** Check this box if you are applying for COBRA coverage (Your Insurance Coordinator will mail this application and your initial payment directly to the Health Insurance Carrier).
- **Other:** Check this box if none of the listed options apply. The Insurance Coordinator must provide a date and an explanation if "Other" is selected.
- **Move Out of Service Area:** Check this box if you are requesting a change to your current health coverage because you have moved out of your service area. You must provide the date of the qualifying event in the space provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator.
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a qualifying event that allows you to select health insurance coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator and must provide supporting documentation, as required.

NOTE TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right hand corner of the application.

- Enter the effective date of coverage.
- If the policyholder selects coverage in his/her Home county, you are required to enter the Home county code. If the policyholder selects coverage in his/her Contiguous county, you are required to enter the Home AND Contiguous county codes.
- Enter policyholder's county of Last Employer, if applicable.
- Enter the retiree's company number.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- If you are not the retiree and you are applying for health insurance coverage, enter your relationship to the retiree (SP = Spouse or CH = Child)
- **RETIREE**: If you are the retiree, enter your Social Security Number and your name (First, MI, Last) and go to *Applicant Specific Information* below.
- **APPLICANT**: If you are not the retiree:
  - Enter the retiree's Social Security Number and the retiree's name (First, MI, Last) in the space labeled *Retiree* above.
  - Enter your Social Security Number and your name (First, MI, Last) under *Applicant*.
  - Go to *Applicant Specific Information*.
- **APPLICANT Specific Information**:
  - Enter the policyholder's Address (including County of Residence), Date of Birth, Primary Phone Number, Smoking Status, Gender and Marital Status in this section. **Note: If the smoking status flag is not checked, this application will be Pended until the information is provided.**

SECTION II: PLAN SELECTION

1. **County of Coverage: Check ONLY one.**
   - **HOME:** If you are electing coverage in the county where you live.
   - **CONTIGUOUS:** This is an additional choice if you live in certain counties in the Commonwealth designated as "Contiguous Counties". If you live in any of the specified counties, you could choose coverage in the county designated as a "Hospital County" that is contiguous to your county of residence. Refer to the Health Insurance Handbook for more information about this option.
   - Enter the name of your county of coverage in the space provided.

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JUDICIAL AND LEGISLATORS RETIREMENT PLANS

2. **Plan Code:** Indicate which health insurance plan you are selecting by entering the three (3) digit code that identifies the health insurance plan. See the Health Insurance Handbook for details.

   IMPORTANT: **If you are waiving coverage, enter 999 as the plan code and go to Section VII.**

   If you are waiving coverage, enter the reason for waiving in the space provided.

3. **Option:** Mark the box that indicates the option you are selecting. For a description of each option, see the Health Insurance Handbook. **Select only one**.

4. **Level of Coverage:** Mark the box that indicates the level of coverage you are selecting. For a description of each level of coverage, see the Health Insurance Handbook. **Select only one**.

5. **Not Applicable.**

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Complete this section only if you are covering your eligible **spouse and/or your dependent child(ren)** on your health insurance plan. Enter the required information for each dependent that you wish to cover. If you need additional space, use Page 1 of another health insurance application. Do not complete this Section if you are selecting Single coverage.

Relationship Code: Enter the appropriate relationship code as follows:

SP Spouse (your eligible spouse).

CH Child (your eligible child, step child, adopted child, foster child or your grandchild that is considered your dependent for Federal Tax purposes and who is not disabled).

DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability annually.

CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance or an eligible dependent child of whom you have full guardianship).

SECTION IV: NOT APPLICABLE

SECTION V: CUSTODIAL PARENT INFORMATION

Complete this section if you have a **Court Order (CO)** or an **Administrative Order** to provide health insurance for an eligible dependent who does not live with you.

- Print your dependent's social security number in the boxes provided.
- Print the custodial parent's name and address in the lines provided. If the custodial parent is the same for each dependent, check the Yes box for "All Dependents?" and complete the custodial parent's name and address only once. If the custodial parent is different for each dependent, complete the appropriate information using an additional page. **Court Ordered dependents MUST also be listed in section III.**

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JUDICIAL AND LEGISLATORS RETIREMENT PLANS

Enter the social security number of the policyholder in the spaces provided on the top right hand corner of Page 2 (same as SSN in *Section I: Demographic Information*).

SECTION VI: NOT APPLICABLE

SECTION VII: AUTHORIZATION AND CERTIFICATION

- Read the statements in this section carefully.
- After you have read and understood the statements, sign your name on the "Retiree Signature or Applicant Signature" line and enter today's date in the line provided.

REMINDER:

DO NOT HOLD YOUR APPLICATION UNTIL THE END OF OPEN ENROLLMENT. RETURN YOUR APPLICATION TO YOUR RETIREMENT PLAN AS SOON AS POSSIBLE.